Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:	MFDR Tracking #: M4-07-3386-01
Renaissance Hospital P.O. Box 11527 Houston, TX 77293-1527	DWC Claim #: Injured Emplo
Respondent Name and Box #:	Date of Injury Employer Nar
American Guarantee & Liability Box # 19	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "Per the stop-loss method the carrier should have reimbursed the provider $61,592.06."

Principle Documentation:

1. DWC 60 package
2. UB-92(s)
3. EOB(s)
4. Total amount sought per DWC-60 is $79,399.76
5. Total amount sought per Letter dated 1-5-07 is $56,309.57

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

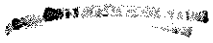
Respondent's Position Summary: "Requestor billed a total of $92,360.76. The Requestor asserts it is entitled to reimbursement in the amount of $69,270.57, which is 75% of the total charges. Requestor has not shown entitlement to this alternative, exceptional method of calculating reimbursement and has not otherwise properly calculated the audited charges."

Principle Documentation:

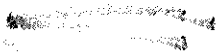
1. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
6-28-06 thru 6-30-06	97, 226, W1, 790	Inpatient Hospitalization	$79,399.76 $56,309.57	$56,309.57
Total Due:				$56,309.57







PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

1. These services were denied by the Respondent with reason code "97-Payment is included in the allowance for another service procedure; 226-Included in global charge; W1-Workers Compensation State Fee Schedule Adjustment; and 790-This charge was reimbursed in accordance to the Texas Medical Fee Guideline."

2. This dispute relates to inpatient services provided in a hospital setting with reimbursement subject to the provisions of Rule 134.401 (Acute Care Inpatient Hospital Fee Guideline). The hospital has requested reimbursement according to the stop-loss method contained in that rule. Rule 134.401(c)(6)(A)(i) states "To be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000, the minimum stop-loss threshold."

3. Based upon the Operative Report, the claimant underwent left total knee arthroplasty.

4. Based upon the UB-92 the total charges were $92,360.76 for the inpatient hospitalization.

5. Because the total audited charges exceed $40,000, the stop-loss method does apply and the reimbursement is to be based on the stop-loss methodology.

6. Rule 134.401(c)(6)(A)(iii), states "If audited charges exceed the stop-loss threshold, reimbursement for the entire admission shall be paid using a Stop-Loss Reimbursement Factor (SLRF) of 75%."

7. Rule 134.401(c)(6)(A)(v), states "Audited charges are those charges which remain after a bill review by the insurance carrier has been performed." The insurance carrier audited the bill and submitted EOBs to support their reduction of billed charges. The insurance carrier audited the bill and paid for services based upon the per diem methodology. No other audit reductions of charges were presented by Respondent.

8. Rule 134.401(c)(6)(B), indicates "Formula. Audited Charges X SLRF = WCRA." Therefore, the amount billed $92,360.76 X 75% = $69,270.57.

9. The insurance carrier audited the bill and paid $12,961.00 for the inpatient hospitalization. The difference between amount due and paid = $56,309.57.

Considering the reimbursement amount calculated in accordance with the provisions of Rule 134.401(c) compared with the amount previously paid by the insurance carrier, the Division finds that additional reimbursement of $56,309.57 is due for these services.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code Sec. §134.401 effective 8-1-97, 133.307
Subchapter G, Chapter 2001, Texas Government Code

PART VII: DIVISION DECISION AND ORDER:

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to additional reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $56,309.57 plus applicable accrued interest per Division Rule 134.130, due within 30 days of receipt of this Order.

ORDER:

Authorized Signature	Director of Medical Fee Dispute Resolution	5/20/08 Date

DECISION:

Authorized Signature	Medical Fee Dispute Resolution Officer	5/20/07 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.